



DIVISION OF HEALTH

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State of Wisconsin

Joe Leean Secretary

Department of Health and Family Services

May 15, 1998

Mental Health Crisis Intervention Providers HMO and Other Managed Care Programs

Dear Sir/Madam:

Enclosed is the first issue of the Wisconsin Medicaid Provider Handbook, Part H, Div. VI for mental health crisis intervention services. This handbook, used with Part A, the all-provider handbook, gives you information needed to provide services to Medicaid recipients and to obtain payment for covered services.

This handbook is designed to assist you in submitting and getting your claims paid quickly and efficiently, and in resolving any billing problems that may be encountered. If you have questions about the information in this handbook, please call the Medicaid Fiscal Agent Policy/Billing Correspondence Unit at (800) 947-9627 or (608) 221-9883.

We will communicate future policy changes through Wisconsin Medicaid Updates.

We would like to thank the crisis intervention program staff who provided invaluable input in developing this handbook.

We appreciate your interest in providing services to Medicaid recipients. Thank you for becoming a Medicaid provider.

Sincerely,

Peggy L. Bartels, Director

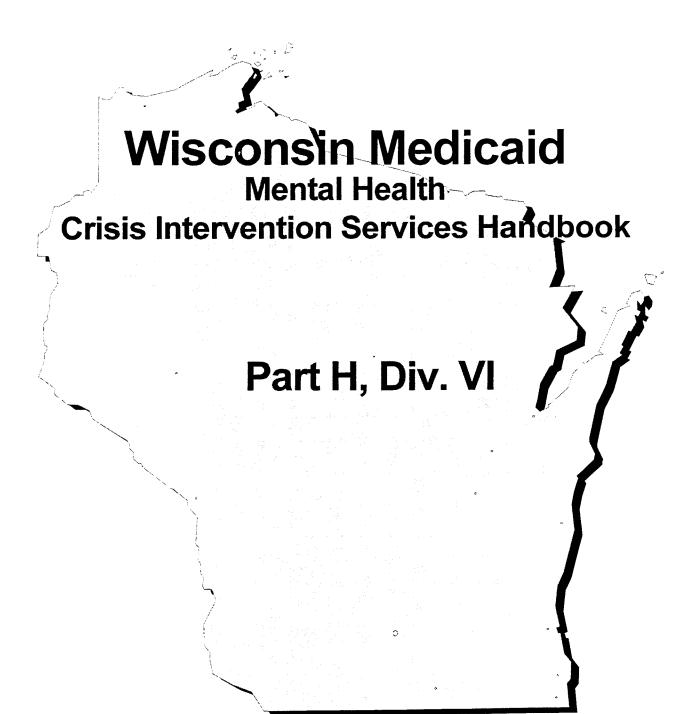
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Enclosure



Department of Health and Family Services
Division of Health
Bureau of Health Care Financing

May 1998

Wisconsin Medicaid Provider Handbook, Part H, Division VI Issued 05/98

Part H, Division VI Mental Health Crisis Intervention Services Transmittal Log

This log is a convenient record sheet for recording receipt of handbook replacement pages. Delete old pages and insert new pages as instructed. Use this log to help eliminate errors and ensure an up-to-date handbook.

Each set of Part H, Division VI, handbook replacement pages is numbered sequentially. This sequential numbering system alerts you to any missing sets of handbook replacement pages. For example, if the last transmittal number on your log is H-3 and you receive H-5, you are missing H-4. You may obtain copies of *complete* provider handbooks by completing the order form in Appendix 36 of Part A, the all-provider handbook.

Transmittal Number	Initials	Issue Date	Т	ransmittal Number	Initials	Issue Date
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Wisconsin Medicaid Provider Handbook, Part H, Division VI Issued 05/98

Introduction

HFS 101-108, Wis. Admin. Code, state statutes, and federal laws govern Wisconsin Medicaid. Medicaid provider handbooks identify the regulations and assist Medicaid providers to comply with requirements. Use the following handbooks when providing services:

- Part A, the all-provider handbook, includes general policy guidelines, regulations, and billing information applicable to all types of certified providers.
- Part H, Division VI, the provider-specific handbook, includes information on provider eligibility criteria, covered services, payment methodology, prior authorization, and billing instructions.
- > The Provider Section of the Wisconsin Medicaid Managed Care Guide includes information on policy guidelines and regulations for AFDC/Healthy Start recipients enrolled in a Medicaid HMO. The AFDC program no longer exists, but the Wisconsin Medicaid program still bases eligibility on AFDC criteria as of July 16, 1996.

Each provider is sent a copy of Part A, the all-provider handbook, the appropriate provider-specific handbook, and the Wisconsin Medicaid Managed Care Guide at the time of certification. Purchase additional copies of provider handbooks by completing the order form in Appendix 36 of Part A, the all-provider handbook.

Read all materials before initiating services to ensure a thorough understanding of Medicaid policy and billing procedures.

Note: Refer to HFS 101-108, Wis. Admin. Code, for a complete source of Medicaid regulations and policies. In the event of any conflict between HFS 101-108, Wis. Admin. Code, and the handbook, the meaning of the Wisconsin Administrative Code holds. For additional copies of HFS 101-108, Wis. Admin. Code, write to Document Sales at the address in Appendix 3 of Part A, the all-provider handbook.

Additional laws and regulations relating to Wisconsin Medicaid include the following:

- > Sections 49.43 49.497, Wisconsin Statutes
- > Title XIX, federal Social Security Act and its enabling regulations, Title 42 Public Health, Parts 430-456

Definitions for common Medicaid terms and abbreviations are in Appendix 30 of Part A, the all-provider handbook, and in HFS 101-108, Wis. Admin. Code.

Wisconsin Medicaid is administered by the Department of Health and Family Services (DHFS). Within the DHFS' Division of Health (DOH), the Bureau of Health Care Financing (BHCF) is directly responsible for managing Wisconsin Medicaid. The DHFS contracts with an outside fiscal agent to provide health claims processing services including:

- Provider certification.
- Claims payment.
- Provider services.
- · Recipient services.

The current Wisconsin Medicaid fiscal agent is EDS.

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A. Type of Handbook

Part H, Division VI, is the provider-specific Medicaid handbook for mental health crisis intervention (hereafter referred to as "crisis intervention") services. Refer to Section II of this handbook for a definition of crisis intervention services. Part H, Division VI, includes information for providers on provider eligibility criteria, recipient eligibility, covered services, payment methods, and billing instructions. Use this handbook in conjunction with Part A, the all-provider handbook, which includes general policy guidelines, regulations, and billing information applicable to all types of certified providers. Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for general policy and regulation information for AFDC/Healthy Start recipients enrolled in a Medicaid Health Maintenance Organization (HMO).

B. Provider Information

Separate Provider Certification Required

Wisconsin Medicaid may pay only county or tribal agencies to provide crisis intervention services as stated in Section 49.45 (41), Wis. Stats. County or tribal agencies, or the agencies the county or tribal agencies contract with to actually provide crisis intervention services, must be certified under HFS 34, Subchapter 3, Wis. Admin. Code.

Wisconsin Medicaid requires the county or tribal agency, and all agencies the county or tribal agency contracts with to provide crisis intervention services, to have separate Medicaid crisis intervention certification. Crisis intervention providers may not use provider certification numbers used for other services, such as community support program (CSP) services, to bill Wisconsin Medicaid for crisis intervention services.

Information for County/Tribal Agencies

To receive Medicaid reimbursement for crisis intervention services, county or tribal agencies must obtain Medicaid certification for billing purposes, even if the county or tribal agency is not a direct provider of crisis intervention services.

Upon Medicaid certification, the county or tribal agency will receive a Medicaid billing provider number. The Medicaid billing provider number indicates that the entity is Medicaid-certified and is responsible to ensure that all Medicaid requirements are met when services are provided. Wisconsin Medicaid sends all payments to the entity that has the Medicaid billing provider number.

Only the county or tribal agency may be the billing provider because the billing provider is responsible for providing the local matching funds for crisis intervention services. Wisconsin Medicaid will certify only one such matching funds agency per county but will certify multiple performing providers per county.

NOTE: Wisconsin Medicaid will certify two billing providers for one county if one is an allowable county agency and one is a tribal government agency.

Refer to the claim form instructions in Appendix 2 of this handbook for information about how to bill for crisis intervention services using the county or tribal agency's Medicaid billing number.

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B. Provider Information (continued)

County or Tribal Agencies That Also Provide Services

County or tribal agencies that provide crisis intervention services must receive a Medicaid non-billing performing provider number in addition to a billing provider number. Wisconsin Medicaid uses this number to ensure that agencies performing crisis intervention services meet the standards under HFS 34, Wis. Admin. Code, and all Medicaid-covered service requirements.

Wisconsin Medicaid does *not* use the non-billing performing provider number to send Medicaid payments. Refer to the claim form instructions in Appendix 2 of this handbook for information about how to bill for crisis intervention services using the county or tribal agency's non-billing performing provider number.

Note: If you are initially Medicaid-certified as a crisis intervention billing provider only, and, at a later date, you are seeking certification as a non-billing performing provider, you must request a non-billing performing provider number from the Medicaid fiscal agent, EDS. Refer to Appendix 7 of this handbook for the Request for a Non-Billing Performing Provider Number form. The Medicaid non-billing performing provider number indicates that the entity is Medicaid-certified and HFS 34-certified.

Crisis Intervention Providers Contracting With County or Tribal Agencies
Crisis intervention providers contracting with a county or tribal agency receive only a
non-billing performing provider number. Crisis intervention providers need approval
from the county or tribal agency to obtain Medicaid certification and to bill Wisconsin
Medicaid. Also, the crisis intervention provider must coordinate billing with the county
or tribal agency.

Wisconsin Medicaid sends all payments to the county or tribal agency listed on the claim form. Refer to the claim form instructions in Appendix 2 of this handbook for information about billing for crisis intervention services as a crisis intervention provider who contracts with a county or tribal agency.

Individual staff do not require certification to provide crisis intervention services. However, clinical staff must meet requirements under HFS 34.21, Wis. Admin. Code.

Application for Certification

For information regarding certification under HFS 34, Wis. Admin. Code, contact:

Program Certification Unit Bureau of Quality Assurance Division of Supportive Living P.O. Box 7851 Madison, WI 53707-7851

For information regarding Medicaid certification, contact:

Provider Maintenance EDS 6406 Bridge Road Madison, WI 53784-0006

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B. Provider Information (continued)

Scope of Service

The policies in Part H, Division VI, govern services provided within the standards defined in HFS 34, Wis. Admin. Code. Refer to Section II of this handbook for covered services and related limitations.

Payment Methods

Medicaid reimbursement is based on a fixed hourly rate. The federal share of this rate is the *hourly* amount the provider receives from Wisconsin Medicaid.

Wisconsin Medicaid has established interim uniform contracted rates for crisis intervention services. In 1998, Wisconsin Medicaid will develop crisis intervention cost reports for the community service deficit reduction benefit (CSDRB) to determine a county's actual cost to provide crisis intervention services. Counties certified as billing providers will receive a cost report to complete. This cost report will serve as the basis for determining the county's actual cost to provide crisis intervention services. Counties will be eligible to receive the federal share of their actual cost to provide crisis intervention services subject to applicable federal limits. Counties will need to certify that they have contributed the local share using public funds eligible for federal financial participation.

Refer to Appendix 5 of this handbook for clarification on matching fund requirements. Refer to Appendix 2 for billing instructions.

Provider Responsibilities

Refer to Section IV of Part A, the all-provider handbook, for provider responsibilities and for information about:

- Fair treatment of the recipient.
- · Maintenance of records.
- Recipient requests for noncovered services.
- Services rendered to a recipient during periods of retroactive eligibility.
- · Grounds for provider sanctions.
- Additional state and federal requirements.

C. Recipient Information

Verifying Recipient Eligibility

Eligible Medicaid recipients receive identification cards monthly that are valid through the end of the month issued. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and, when applicable, an indicator of health insurance, HMO, and Medicare coverage.

Note: Check the recipient's identification card before providing service to determine recipient eligibility and any limitations to the recipient's coverage.

Section V of Part A, the all-provider handbook, provides detailed information about eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and eligibility verification. Review Section V of Part A, the all-provider handbook, *before* providing services. A sample identification card is in Appendix 7 of Part A, the all-provider handbook.

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C. Recipient Information (continued)

Copayment

Wisconsin Medicaid does not require copayment for crisis intervention services.

Recipients Enrolled In Managed Care Programs

Providers must check the recipient's current identification card for managed care program coverage before providing services. Recipients enrolled in a Medicaid-contracted managed care program receive a yellow identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. Refer to Chapter 4 of the Provider Section of the Wisconsin Medicaid Managed Care Guide for the HMO Medicaid ID codes.

For recipients enrolled in a Medicaid managed care program, the contract between the managed care program and certified provider establishes all conditions of payment and prior authorization for crisis intervention services.

Except for recipients enrolled in the Wraparound Milwaukee program, Wisconsin Medicaid denies claims submitted to the fiscal agent for crisis intervention services provided to a recipient enrolled in a Medicaid managed care program. Refer to next page of this handbook for more information on specialized managed care programs.

Refer to the Provider Section of the Wisconsin Medicaid Managed Care Guide for more information about managed care program noncovered services, emergency services, and hospitalizations.

Crisis Intervention and Medicaid Managed Care

AFDC/Healthy Start HMOs

All HMOs serving the AFDC population must have a Memorandum of Understanding (MOU) with each county's responsible human service department or board created under s. 51.42, Wis. Stats. in their service area. This MOU must address coordination of care for common clients. If the county is also a service provider, payment for service issues may be addressed through the MOU or a formal provider contract.

HMOs serving the AFDC population must reimburse non-HMO providers for emergency mental health or AODA treatment services if the time required to obtain such treatment at the HMO's facilities would have risked permanent damage to the enrollee's health or safety, or the health or safety of others.

When appropriate emergency treatment is provided by a non-HMO provider to an HMO enrollee, the non-HMO provider must notify the HMO within 72 hours of initiating services. The HMO is liable for the cost of the first 72 hours of care.

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C. Recipient Information (continued)

The HMO's liability for appropriate emergency treatment is the current Medicaid feefor-service rate for such treatment. Upon notification within 72 hours, the HMO is responsible for payment of additional care only if given the opportunity to provide such care.

Specialized Managed Care Programs

Crisis intervention is separately reimbursable on a fee-for-service basis for the Wraparound Milwaukee program only. Providers may identify Wraparound Milwaukee recipients by the code "MCPWAM" in the "Other Coverage" section of the Medicaid identification card, and the sentence, "Mental Health Services Only Thru WAM," listed above the recipient's name and address on the ID card. For all other specialized managed care programs, providers must seek reimbursement directly from the managed care program. Wisconsin Medicaid encourages crisis intervention providers to contact managed care providers in their area to discuss how to handle mental health crisis situations.

Crisis Intervention and Community Support Programs (CSP)

Wisconsin Medicaid covers crisis intervention services for individuals receiving Medicaid-funded CSP services when:

- The crisis intervention program has a formal arrangement with the CSP to provide crisis services to CSP enrollees.
- The crisis intervention services are delivered according to a crisis plan developed by the crisis intervention program and the CSP.
- The crisis intervention services do not duplicate CSP services.

NOTE: The crisis intervention program may not claim Medicaid reimbursement if reimbursement for the crisis intervention services is claimed through the CSP.

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A. Introduction

Definitions

Wisconsin Medicaid uses the following definitions:

- 1. "Crisis" means "a situation caused by an individual's apparent mental disorder which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public which cannot be resolved by the available coping methods of the individual or by the efforts of those providing ordinary care or support for the individual" [HFS 34.02 (5), Wis. Admin. Code].
- 2. "Crisis Plan" means "a plan prepared under s. HFS 34.23 (7) for an individual at high risk of experiencing a mental health crisis so that, if a crisis occurs, staff responding to the situation will have the information and resources they need to meet the person's individual service needs" [HFS 34.02 (6), Wis. Admin. Code].
- 3. "Emergency mental health services" means "a coordinated system of mental health services which provides an immediate response to assist a person experiencing a mental health crisis" [HFS 34.02 (8), Wis. Admin. Code].
- 4. "Response Plan" means "the plan of action developed by program staff under s. HFS 34.23 (5) (a) to assist a person experiencing a mental health crisis" [HFS 34.02 (20), Wis. Admin. Code].
- 5. "Stabilization Services" means "optional emergency mental health services under s. HFS 34.22 (4) which provide short-term, intensive, community-based services to avoid the need for inpatient hospitalization" [HFS 34.02 (21), Wis. Admin. Code].

B. Covered Services

What Is Crisis Intervention?

Crisis intervention services are services provided by an emergency mental health services program to an individual in crisis or in a situation that may develop into a crisis if professional supports are not provided. All crisis intervention services must conform to the standards in HFS 34, Subchapter 3, Wis. Admin. Code. References to appropriate sections of HFS 34, Wis. Admin. Code, in this handbook are identified in parentheses. Refer to Section IB, of this handbook for information on how to obtain more information about provider certification under HFS 34, Wis. Admin. Code.

Recipient Eligibility for Crisis Intervention Services

Wisconsin Medicaid covers an initial contact and assessment for any recipient contacting the crisis intervention provider. For recipients not in a crisis, the length of the assessment must be no longer than what is required to determine that no crisis or emergency exists and to make appropriate referrals, when indicated.

Wisconsin Medicaid covers all other crisis intervention services only if the provider documents that both of the following are true:

- The recipient is in a crisis or in a situation that may develop into a crisis if professional supports are not provided.
- The provider can expect to reduce the need for institutional treatment or improve the recipient's level of functioning.

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Wisconsin Medicaid covers crisis intervention services for recipients being discharged from an institutional setting (hospital or nursing home) only if the provider documents the following in the recipient's records:

- Why the recipient is likely to experience an emergency or a crisis if the crisis intervention services are not provided.
- Why other services that might maintain the recipient in the community are not available and when such services are likely to be available.

Recipients are not eligible for any Medicaid services during periods of time when they are in jail or secure detention.

General Requirements

Wisconsin Medicaid covers crisis intervention services when all the requirements in this section are met.

Providers may provide crisis intervention services by the following means:

- Over the telephone.
- In person at any location where a recipient is experiencing a crisis or receiving services to respond to a crisis.

Providers must document the means and place of service in the recipient's record.

Travel and Recordkeeping Time

Wisconsin Medicaid covers staff travel time to deliver covered crisis intervention services and the recordkeeping time associated with delivering the services. Travel and recordkeeping are not separately billed. They are billed as part of the covered service. That is, the provider adds up the service time, travel time (if any), and recordkeeping time, and bills this total when billing for a service.

Example: If a provider spends 20 minutes travelling to a recipient, 1 hour providing covered crisis intervention services, and 5 minutes completing recordkeeping associated with those services, the provider must bill all of this time together (as 1.5 billing units) on the HCFA 1500 claim form. Refer to Appendix 6 of this handbook for guidelines for rounding time and for the appropriate billing units for crisis intervention services. NOTE: Travel time is not covered if no covered service was provided.

Multiple Crisis Intervention Staff and Staff Time

Wisconsin Medicaid covers more than one staff person providing crisis intervention services to one recipient simultaneously if multiple staff are needed to ensure the recipient's or the provider's safety (e.g., the recipient is threatening to hurt others). Providers must clearly identify the number of staff involved when billing for more than one staff person and the rationale for multiple staff in their documentation.

Refer to the billing section (Section III) of this handbook for information about how to bill for multiple staff.

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Crisis Service Hours

Wisconsin Medicaid covers only services that are directed toward solving and preventing crises under the crisis intervention benefit. Providers must use the crisis plan or response plan to document how services are related to these goals.

For services meeting the above criteria, Wisconsin Medicaid does *not limit* the number of crisis service hours that may be reimbursed through the claims system for services provided to a recipient per day. Also, there is no limit on the length of time that crisis services are covered for a given recipient. Providers must use the response and crisis plans to document service needs and to justify the need for continued services.

Wisconsin Medicaid monitors the use of crisis intervention services retrospectively through data analysis and auditing.

Crisis Intervention Covered Services

Initial Assessment and Planning

This service includes the following:

- The initial contact and assessment [HFS 34.23 (3) and (4), Wis. Admin. Code], including referral to other services and resources, as necessary, when further crisis intervention services are not required.
- The response plan's development per HFS 34.23 (5), Wis. Admin. Code, when required.

Crisis Linkage and Follow-Up

Crisis linkage and follow-up include the following:

- 1. Reviewing and updating the response plan and development, review, and updating of the crisis plan.
- 2. Follow-up interventions prescribed in a response plan or crisis plan or other interventions approved by a psychiatrist or psychologist to meet the following goals:
 - Relieve the recipient's immediate distress in a crisis or pre-crisis.
 - Reduce the risk of a worsening crisis.
 - Reduce the level of risk of physical harm to the recipient or others.
 - Resolve or manage family crises to prevent out-of-home placements of children, improve the child's and family's coping skills, and assist the family in using or obtaining ongoing mental health and other supportive services.
 - Assist the recipient in making the transition to the least restrictive level of care.
- 3. Linkage activities designed to:
 - Provide evaluation, referral options, and other information to a recipient or others involved with the recipient.

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- Coordinate the resources needed to respond to the situation.
- Assist in the recipient's transition to the least restrictive level of care required.
- Follow-up to ensure that intervention plans are carried out and meeting the recipient's needs.
- Resolve or manage family crises to prevent out-of-home child placements, improve the child's and family's coping skills, and help the family use or obtain ongoing mental health and other supportive services.

Crisis Stabilization Services

Crisis stabilization services include professional supports identified on the response plan or crisis plan provided in any of the following settings (list is not all-inclusive):

- · Adult family home.
- Child caring institution.
- Community-based residential facility.
- Crisis hostel.
- Foster or group home.
- Outpatient clinic.
- · Person's home.
- School.

When professional staff of the crisis intervention program who are not staffing a 24-hour in-residence stabilization program provide stabilization services, the crisis intervention program must bill stabilization services using the procedure codes for crisis stabilization listed in Appendix 3. Wisconsin Medicaid reimburses these codes on an hourly basis. Wisconsin Medicaid covers only those stabilization services necessary for:

- Reducing or eliminating an individual's symptoms of mental illness so that the person does not need inpatient hospitalization.
- Assisting in the transition to a less restrictive placement or living arrangement when the crisis has passed.

Services Covered for Recipients in Inpatient Hospitals and Nursing Facilities

The only services covered for recipients in an inpatient hospital or a nursing facility are:

- Development of a crisis plan.
- Services to assist the recipient in making the transition to a less restrictive level of care.

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Approval of Covered Services

A psychiatrist or a licensed psychologist listed, or eligible for listing, in the National Register of Health Care Providers in Psychology must approve all services *except*:

- Initial contact and assessment, including the initial response plan's development.
- Crisis or response plan reviews.
- Crisis or response plan updates.

The psychiatrist or psychologist must document his/her approval with one of the following methods:

- Signing the crisis plan.
- Signing the response plan.
- Signing or cosigning contact notes.

Response Plan

According to HFS 34.23 (5), Wis. Admin. Code, a psychiatrist or licensed psychologist must approve the initial response plan within five working days after services are first delivered. After the initial response plan has been approved, signed, and implemented, the psychiatrist or licensed psychologist must review and sign the response plan at least monthly, even if changes are made more often. Wisconsin Medicaid covers all services identified on the response plan which meet the covered services requirements outlined in this section if the response plan has been reviewed and updated and signed by a psychiatrist or licensed psychologist within the past month.

Crisis Plan

Wisconsin Medicaid covers services identified on the crisis plan that meet the covered services requirements outlined in this section if the crisis plan has been reviewed and updated and signed by a psychiatrist or licensed psychologist within the past six months. The psychiatrist or licensed psychologist must review and sign the crisis plan at least only once every six months, even if changes are made more often.

Contact Notes

The psychiatrist or licensed psychologist must sign a contact note within five working days of when the documented service was provided. The psychiatrist or licensed psychologist does not need to sign individual contact notes if the service provided was identified on a response plan or crisis plan which the psychologist or psychiatrist signed according to the requirements noted in *Response Plan* and *Crisis Plan*.

Documentation

In addition to the requirements under HFS 105.02 (4) and (6) and 106.02 (9), Wis. Admin. Code, providers must maintain documentation of staff qualifications per HFS 34.21 (3), Wis. Admin. Code.

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Throughout the recipient's records, documentation must include whether the contact with the recipient and others was a personal, phone, or written contact. If the contact was a personal contact, documentation must include the location where the personal contact was made. Recipients' records must contain the following types of documentation:

- Initial contact and assessment.
- The recipient's eligibility for services.
- Service approval by a psychiatrist or psychologist.
- Development of response plans.
- Development of crisis plans.

Documentation that the recipient is in a crisis or a situation that is likely to develop into a crisis must be sufficient to demonstrate that the conditions outlined at HFS 34.02 (5), Wis. Admin. Code, are met. The provider does not need to separately document this information if it is contained in the initial contact and assessment.

Note: Refer to Section I of this handbook and earlier in this section (Section II) for more information about required documentation for crisis intervention services.

C. Related Limitations

Wisconsin Medicaid does not cover services as crisis intervention services when Wisconsin Medicaid has paid for the same service through another benefit. This includes:

- Alcohol and other drug abuse (AODA) outpatient services.
- AODA day treatment services.
- Case management services.
- Community support program (CSP) services.
- Day treatment or day hospital services.
- Hospital outpatient service.
- Outpatient psychotherapy service.

For example, when the provider helps the recipient find appropriate housing, Wisconsin Medicaid may cover this activity as a covered service under both the crisis intervention benefit and the case management benefit. Assuming all criteria are met, Wisconsin Medicaid will reimburse the provider who is certified in both programs under one of these benefits but not both.

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C. Related Limitations (continued)

Wisconsin Medicaid covers crisis intervention services provided on behalf of Medicaid recipients only and covers crisis intervention contacts with only the following persons:

- The recipient.
- A family member(s), guardian(s), friend(s), or other individual(s) assisting the recipient.
- Professionals, paraprofessionals, or others providing resources required to respond to the crisis.

D. Noncovered Services Wisconsin Medicaid does not cover the following as crisis intervention services:

- Room and board.
- Volunteer services not meeting the qualifications in HFS 34.21 (3), Wis. Admin.
- Services other than those listed in this section.
- Services that are social or recreational in nature.

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A. Coordination of Benefits

Crisis Intervention and Health Insurance

If the recipient's Medicaid identification card indicates health insurance, providers must seek payment first from the health insurer. If you receive payment from the health insurer, enter the other insurance indicator (OI-P) in element 9 of the HCFA 1500 claim form and indicate the amount in element 29 of the HCFA 1500 claim form. Leave element 9 blank if you do not receive payment from the health insurer.

If no health insurance is indicated on the recipient's Medicaid identification card, do not enter any information in element 9 of the HCFA 1500 claim form.

Refer to Appendix 2 of this handbook for more information about completing HCFA 1500 claims for crisis intervention services.

B. Medicare/Medicaid Dual Entitlement

Dual-entitlees are recipients covered under both Medicare and Wisconsin Medicaid. Since crisis intervention is not a Medicare-covered service, providers should not seek Medicare payment. Therefore, providers must leave element 11 of the HCFA 1500 claim form blank.

C. QMB-Only Recipients

Qualified Medicare Beneficiary Only (QMB-only) recipients are eligible only for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does not cover crisis intervention services, Wisconsin Medicaid does not pay the coinsurance and deductible for crisis intervention services.

D. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a non-Medicaid patient. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for the service provided. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

E. Managed Care Recipients

Refer to Section I of this handbook for information regarding billing for crisis intervention services provided to recipients who are enrolled in AFDC/Healthy Start HMOs or specialized managed care programs.

F. Presenting Problem Codes

When a recipient has a problem that needs crisis intervention services, these problems are called "presenting problems." Presenting problems are described in four-character codes that identify the presenting problems. Enter presenting problem codes in element 21 of the HCFA 1500 claim form. Providers may enter up to three codes on the claim form. Refer to Appendix 4 of this handbook for allowable presenting problem codes and to Section II of this handbook for more information about covered crisis intervention services.

Presenting problem codes are Medicaid codes. *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) coding structure is not used to identify or describe presenting problem codes.

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G. Procedure Codes

All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Wisconsin Medicaid denies claims or adjustments received without HCPCS codes. Refer to Appendix 3 of this handbook for allowable HCPCS codes and their description and to Appendix 8 of this handbook for staff qualifications for crisis intervention billing levels.

H. Quantity

Bill all services in hourly units. Refer to Appendix 6 of this handbook for rounding guidelines.

I. Place of Service

Refer to Appendix 6 of this handbook for a complete list of allowable place of service (POS) codes. Enter POS codes in element 24b on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.

J. Type of Service

For crisis intervention services, the type of service (TOS) is always "1" on the HCFA 1500 claim form. Enter the TOS in element 24c on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.

K. Billing for Multiple Staff

When two or more staff are providing services at the same time and using the same procedure code (e.g., W9558 - two "other" staff providing crisis linkage and follow-up), the providers must accumulate their time and bill using only one line on the claim form.

Example of billing for multiple staff: A nurse and a social worker provide three hours of crisis linkage and follow-up together. Appendix 8 of this handbook shows that both of these professionals are at the RN/MS billing level; therefore, these services are both under the same W9557 procedure code. When billing for crisis linkage and follow-up, these staff members must bill under procedure code W9557 for a total of six hours and combine their total charges for these services. All of this information must be entered in the appropriate place on the same line of element 24 on the HCFA 1500 claim form.

L. Claim Submission

Paper Claim Submission

Submit claims using procedure codes for crisis intervention services on the HCFA 1500 claim form. Wisconsin Medicaid denies claims for crisis intervention services submitted on any other paper form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Neither Wisconsin Medicaid nor the fiscal agent provide the HCFA 1500 claim form. Claim forms are available from many suppliers. One supplier is:

State Medical Society Services Post Office Box 1109 Madison, WI 53701 (608) 257-6781 (Madison area) (800) 362-9080 (toll-free)

Mail completed claims for payment to:

EDS 6406 Bridge Road Madison, WI 53784-0002

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L. Claim Submission (continued)

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent may process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. All claims that providers submit are subject to the same Medicaid legal requirements. Providers submitting electronically usually reduce their claim submission errors. For more information on paperless claim submission, contact:

EMC Department EDS 6406 Bridge Road Madison, WI 53784-0009 (608) 221-4746

Claims Submission Deadline

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

M. Follow-Up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. The fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- · Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.

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APPROVED OMB-0938-0008

Appendix 1 Sample HCFA 1500 Claim for Crisis Intervention Services

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Appendix 2 HCFA 1500 Claim Form Completion Instructions for Crisis Intervention Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when requested. All elements are required unless "not required" is specified.

Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers must always see this card before providing services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator

Enter claim sort indicator "P" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's I.D. Number

Enter the recipient's 10-digit identification number from the current identification card. Do not indicate any other numbers unless the claim is a Medicare crossover claim. In this case, the recipient's Medicare number may also be indicated.

Element 2 - Patient's Name

Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex

Enter the recipient's birth date in MM/DD/YY format (i.e., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address

Enter the complete address of the recipient's place of residence.

Element 6 - Patient Relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name

Do not enter anything in this element if no health insurance is indicated under "Other Coverage" on the recipient's identification card.

If the recipient's Medicaid identification card indicates private health insurance under "Other Coverage," you must attempt to bill the private health insurance. If you receive payment from the private insurer, indicate the following code in the first box of element 9:

Code Description

OI-P Use the OI-P disclaimer code when the health insurance pays in part. The claim indicates the amount paid by the health insurance company to the provider or the insured.

Leave this element blank if the other insurer denies payment.

Element 10 - Is Patient's Condition Related to (not required)

Element 11 - Insured's Policy, Group, or FECA Number

Leave this element blank.

Elements 12 and 13 - Authorized Person's Signature

(Not required since the provider automatically accepts assignment through Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient Has Had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - I.D. Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use (not required)

Element 20 - Outside Lab (not required)

Element 21 - Diagnosis or Nature of Illness or Injury

Enter a presenting problem code here. Refer to Appendix 4 of this handbook for a list of presenting problem codes. List the main presenting problem first. The presenting problem description is not required.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization (not required)

Element 24a - Date(s) of Service

Enter the month, day, and year for each procedure using the following guidelines.

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing *only* the date(s) of the month (e.g., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if all of the following apply:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.

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- The charge for each procedure is identical. (Enter the total charge per detail line in element 24f.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck indicator.
- All procedures have the same emergency indicator.

Element 24b - Place of Service

Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 6 of this handbook for a list of allowable place of service codes for crisis intervention services.

Element 24c - Type of Service Code

Enter the type of service code "1" here.

Element 24d - Procedures, Services, or Supplies

Enter the appropriate five-character procedure code. Refer to Appendix 3 of this handbook for a list of allowable procedure codes for crisis intervention services.

Element 24e - Diagnosis Code

Enter the number (1, 2, 3, or 4) which corresponds to the appropriate presenting problem code in element 21.

Element 24f - Charges

Enter the total charge for each line.

Element 24g - Days or Units

Enter the total number of services billed for each line. Refer to Appendix 6 for appropriate billing units.

Element 24h - EPSDT/Family Planning

Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. If HealthCheck does not apply, leave this element blank.

Element 24i - EMG (not required)

Element 24j - COB (not required)

Element 24k - Reserved for Local Use

Enter the eight-digit provider number of the performing provider *for each procedure*. This is different from the billing provider number used in element 33. Enter your non-billing performing provider number here, if you are a county or tribal agency that is also a performing provider.

When applicable, enter the word "spenddown" and under it, enter the spenddown amount on the last detail line of element 24k directly above element 30. Refer to Section IX of Part A, the all-provider handbook, for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.

Optional - The provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent Remittance and Status Report.

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Element 27 - Accept Assignment

(Not required, provider automatically accepts assignment through Medicaid certification.)

Element 28 - Total Charge

Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by the health insurance. If the other health insurance denied the claim, enter \$0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

Element 30 - Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24k and the amount paid by health insurance in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or an authorized representative must sign in element 31. Also enter the month, day, and year the form is signed in MM/DD/YY format.

Note: This may be a computer-printed or typed name and date or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, Zip Code, and Telephone

Enter the billing provider's name (exactly as indicated on the provider's notification of certification letter) and address. At the bottom of element 33, enter the billing provider's eight-digit provider number. This will always be the county or tribal agency's Medicaid billing number.

Appendix 3 Procedure Codes for Crisis Intervention Services

Procedure Codes

Code	Description
W9551	Initial assessment and planning - MD
W9552	Initial assessment and planning - PhD
W9553	Initial assessment and planning - MS/RN
W9554	Initial assessment and planning - Other
W9555	Crisis linkage and follow-up - MD
W9556	Crisis linkage and follow-up - PhD
W9557	Crisis linkage and follow-up - MS/RN
W9558	Crisis linkage and follow-up - Other
W9559	Crisis stabilization - MD
W9560	Crisis stabilization - PhD
W9561	Crisis stabilization - MS/RN
W9562	Crisis stabilization - Other

For information on staff qualifications for crisis intervention billing levels, refer to Appendix 8 of this handbook.

Appendix 4 Presenting Problem Codes for Crisis Intervention Services

Presenting Problem Codes

The presenting problem is the reason the recipient needs crisis intervention services. You must enter a presenting problem code (listed below) in element 21 of the HCFA 1500 claim form. You may enter up to three codes, but enter the primary presenting problem first. These codes correspond to the codes used in the Human Services Reporting System (HSRS) mental health module.

Code	Description
01CR	Marital/Family problem
02CR	Social/Interpersonal (other than family problem)
03CR	Problems coping with daily roles and activities (includes job, housework, daily grooming, financial management, etc.)
04CR	Medical/Somatic
05CR	Depressed mood and/or anxious
06CR	Attempt, threat, or danger of suicide
07CR	Alcohol
08CR	Drugs
09CR	Involvement with criminal justice system
10CR	Eating disorder
11CR	Disturbed thoughts
12CR	Abuse/Assault/Rape victim
13CR	Runaway behavior
14CR	Emergency detention

Appendix 5 Matching Fund Requirements

Wisconsin Medicaid funds are a combination of state and federal funds. In order for the state to collect the approximately 60 percent federal share, Wisconsin Medicaid has to secure approximately 40 percent as the state share. For Medicaid crisis intervention, existing state and local funding will constitute this state match. This could be county tax levy or any state GPR aids allocated to county agencies administering crisis intervention services to eligible recipients. This has two implications:

- First, when an agency submits a bill to the fiscal agent for the actual allowable hours of the crisis intervention services, the fiscal agent pays the federal share to the county agency, subject to reimbursement limits set by the Department of Health and Family Services (DHFS).
- Second, Medicaid-certified crisis intervention agencies must have sufficient state or local funding to serve as the non-federal share of crisis intervention reimbursement and must maintain an audit trail to document expenditures for eligible recipients.

There are two limitations on funds allowable for matching funds:

- 1. Federal monies may not be used to match the federal share of Medicaid dollars, unless the federal funds are authorized by the federal government for this purpose.
- 2. Local funds already being used to match other federal funds may not be used as a match for crisis intervention. Examples of this include:
 - The same local funds may not be claimed as a match for Community Support Program (CSP) services and crisis intervention.
 - The same local funds may not be claimed as a match for maternal/child health block grants and crisis intervention.

Bona fide donations may be used as matching funds. Bona fide donations are defined in 42 CFR 433.54.

Providers are encouraged to contact Wisconsin Medicaid at the address below if providers are considering using funds other than county tax levy or community aids allocated to your agency as the local funds.

Write to: Mental Health Policy Analyst Bureau of Health Care Financing P.O. Box 309 Madison, WI 53701-0309

Appendix 6 Rounding Guidelines and Allowable Place of Service Codes

The following chart illustrates the rules of rounding and gives the appropriate billing unit(s).

Billing in One-Tenth Hour Increments:

Time (in minutes)	Unit(s) Billed
1 - 6	.1
7 - 12	.2
13 - 18	.3
19 - 24	.4
25 - 30	.5
31 - 36	.6
37 - 42	.7
43 - 48	.8
49 - 54	.9
55 - 60	1.0
etc.	

Place of Service Codes

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility

Appendix 7 For Mental Health Crisis Intervention Billing Providers: To Request a Non-Billing Performing Provider Number

If you are a county or tribal government agency that is certified as the billing provider in your county (the agency that provides the matching funds) and you are seeking HFS 34, Subchapter 3 certification to perform crisis intervention services, you must complete the following steps to notify the Medicaid fiscal agent, EDS:

- 1. Complete this form and send it to the fiscal agent at the same time you request an HFS 34, Subchapter 3 certification application from the Division of Supportive Living (DSL).
- 2. Send a copy of the HFS 34, Subchapter3 certificate to the fiscal agent within 30 days of DSL approval. This will allow the fiscal agent to assign you the earliest possible effective date for a non-billing performing provider number. If the fiscal agent receives the copy of the HFS 34, Subchapter 3 certificate more than 30 days after DSL approval, the effective date of the non-billing performing provider number will be the date the fiscal agent receives the copy of your HFS 34, Subchapter 3 certificate.
- 3. Include your new non-billing performing provider number on claims for services your agency performs on and after the effective date assigned to your non-billing performing provider number.

If you obtain HFS 34, Subchapter 3 certification for separate locations, use this form to request a separate non-billing performing provider number for *each* location.

Please photocopy this page so you can retain the original in your handbook.

Mental Health Crisis Intervention Billing Provider Name:			
Address:			
Street	City	Zip	
(The physical location of your agency performing the	ese services; this must match the address	s used on the HFS 34 application.)	
IRS Number:	Billing Provider # :		
Medicaid Contact Person:	Phone:		
(You may want someone listed other than the indivi	dual listed on your billing provider file.)		
Signature:	Date:		

Please send this completed form to the following address:

Provider Maintenance EDS 6406 Bridge Rd. Madison, WI 53784-0006

Appendix 8 Staff Qualifications for Mental Health Crisis Intervention Billing Levels

Wisconsin Medicaid defines four billing levels for crisis intervention staff. The following crosswalk identifies at which level crisis intervention agencies must bill for staff services. Staff qualifications are based on program staff definitions in HFS 34.21 (3) (b) 1-19, Wis. Admin. Code.

Crosswalk Between Medicaid Billing Levels and Staff Specialties		
Medicaid Billing Level	Staff Specialty	
MD	Psychiatrists Psychiatric residents	
Ph.D.	Psychologists	
MS/RN	Certified independent clinical social workers Certified social workers Master's-level clinicians Occupational therapists Post-master's-level clinician interns Professional counselors and marriage and family therapists Psychiatric nurses Psychology residents Registered nurses	
Other	Certified occupational therapy assistants Clinical students Licensed practical nurses Mental health technicians Other qualified mental health professionals Physician assistants Specialists in specific areas of therapeutic assistance	

These groupings are for the purpose of determining billing levels only. The clinical responsibility and authority of staff at various levels is dictated by HFS 34, Wis. Admin. Code, and Wisconsin Medicaid policies as outlined in the crisis intervention handbook.

Example: Although you bill psychiatric resident services at the same level as a psychiatrist's services, the resident may not approve services by signing off on the response plan or crisis plan. According to HFS 34.23 (5) (b) and (7) (d), Wis. Admin. Code, and Medicaid policies only a psychiatrist or licensed psychologist who is listed or eligible to be listed in the national register of healthcare providers in psychology may approve services.

Example: Although you bill registered nurse services at the same level as master's-level social worker services, the registered nurse does not have the authority to supervise staff that is given to providers meeting the qualifications of HFS 34.21 (3) (b) 1. to 8., Wis. Admin. Code.